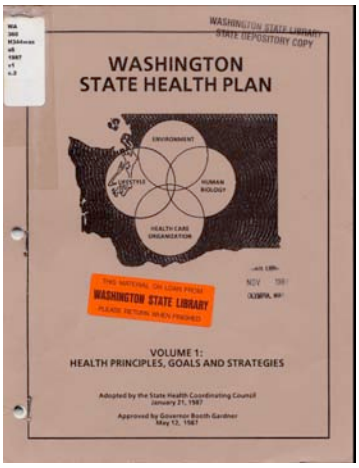

STATE HEALTH PLANNING POTENTIAL OPTIONS

This compendium of information was provided to the Task Force to put health planning in perspective, both locally and nationally. It includes Washington health planning history, other planning efforts, health plans in other states, potential future models, probable resources needed, and past efforts since 1984. These are option to help stimulate your thinking.

Washington State—Past History (see attached addendum)

Planning based on the Certificate of Need established in statute in 1971, followed by the National Health Planning Act of 1974.
Elimination of the authorization for the NHPA in 1984 resulted in loss of funding and overtime the planning process varied with each Governor.
Implementation of the safety net program pilot in 1989 and subsequent establishment of the Basic Health Plan in 1991.
Health Care Reform of the 1990's authorized the managed care model (Alain Enthoven), prospective payment systems, and a collective state purchasing model.

Washington State Current Planning Process

Board of Health prepares a report on the status of health in the state.
Each department involved in health care delivery does planning, some of which is based on POG, Governor's 14 health initiatives, their individuals prioritizations.
EX:

DOH-has state plans for Public Health Improvement, Health of Washington State, cardiovascular disease and stroke (CDC based), asthma, diabetes, disaster planning for pandemic flu, etc.

BOH-establishes recommendations for state vaccine strategic plan, etc.

DSHS/HRSA-2 yr strategic plan based on POG, integration plan for mental health, chemical dependency, and physical health; chronic disease management, health disparities, managed care pilots for elderly and disabled, nursing homes, etc.

HCA-development of strategic plan, benefits management for prevention, restructuring of the purchase of health insurance, EMR/RHIO, CON, reorganization of CHS, expansion of BH, etc.

DOC-FFS purchasing

L&I—FFS purchasing under prospective payments, analysis and intervention for high utilization of opiates. Some integration across agencies: PDP, SHTAP, chronic disease management, strategies for auditing of state contracted plans, managed care model, reimbursement re-basing system, etc.

Examples of State Planning Processes from Select Other States:

States	Planning/Policy	Features	Current	Comprehensive	CON
Kentucky	Gov. Office of Health Policy/Planning	Benefit mgmt, policy coordination, analysis of data	Yes, 2 yr plan	Limited to services and facilities	Official Health Plan
Maine	Office of Health policy and Finance: Health Data Advisory Committee	Quality, cost, access, and prevention	Yes	Yes, this is state initiative for health reform, Dirigo Health Plan	Part of Dirigo Health Plan and Reform Plan
Vermont	DOH, Sec of Human Services	Health promotion, chronic illness, disease prevention, disparities	New, summer 2006	Limited to services and facilities	Largely CON
Minnesota	DOH	Includes local and state planning, HMO planning, genomics and chronic disease	Yes	Yes, tailored to the high HMO penetration in the State	None
North Carolina	DHHS	Focus on facilities and services	Yes	Comprehensive	Part of Health Plan
West Virginia	Health Care Authority's mission	Workforce, access, quality, cost, uninsured	Yes	Comprehensive	Part of Health Plan

Three (3) Health Planning Model Options:

A. Commission on Health Planning composed of state health agencies and external partners
   1. Major considerations:
      a. Establish a new agency
      b. May have too many special interests that would slow down process
B. State Health Planning located in Governor's office
   1. Major considerations:
      a. Already established health policy office
      b. Integrated approach, alignment with POG, GMAP, initiatives, etc, for greater efficiency
      c. Comprehensive, flexible decision making through out the year
      d. Level playing field for all the agencies
C. State Health Planning located in designated agency involved in health care
   1. Major considerations:
      a. Potential perception as the designated agency's plan, not the state's.
      b. Uneven distribution of resources for staffing, data analysis, etc.
      c. Potentially viewed as an un-level playing field.
      d. Each agency has their own policy people.

Two (2) Scope of Content Options for a Health Planning Model:

A. Comprehensive scope of content/focus
   1. Areas of Focus:

Mental Health	Physical Health
Correctional Health	Facilities
Worker's Compensation	Services
Public Health	Genomics
Preventive Health	Electronic health technology (EMR, RHIO)
Environmental Health	Dental Health
Financials	Disaster Detection, Planning, & Monitoring

   Data-claims and provider encounters could be used to develop patterns of disease for disaster planning, besides other aspects of health care purchasing, P4P, etc.
   Complimentary Alternative Care
   2. Readily Identifiable Pros:
      a. Could serve as a dynamic blue print for quality, cost, and access = health business plan for the state
      b. Could serve as basis for prioritization of state needs
      c. Could serve as foundation for coordination/integration of all state agency's strategic plans
      d. Aligns with scope of Governor's Health Initiatives
   3. Readily Identifiable Cons:
      a. Complex, requiring a staged approach
      b. Could require new legislation to implement

B. Narrow scope of content/focus
   1. Areas of Focus:
      a. limited to facilities/services within CON program scope of coverage
   2. Readily Identifiable Pros:
      a. Less complex
      b. Requires little or no increase in staff
      c. May require no new legislation to implement
   3. Readily Identifiable Cons:
      a. Addresses only the capacity management component/function thru regulation
      b. Does not address under, over, and mis-utilization that is not managed in a regulatory function like CON
      c. Does not provide basis for prioritization of state needs
      d. Does not provide foundation for coordination/integration of all agency's strategic plans
      e. Does not fully address the Governor's Health Initiative

Required Resources for all Health Planning Models:

A. Budget
B. Staff, including technical staff to meet the model's needs
C. Centralized data collection and analysis
D. Legislative mandate, is not within present scope of existing agencies

Year	Commission / Study	Origin	Purpose
1984	Six-Year State Health Care Purchasing Plan Steering Committee (Governor Spellman)	SSB 4403, 1984 session	Address issue of increasing state health care expenditures, including (1) make recommendations on achieving savings in state health care expenditures and (2) summarize historical, current, and forecasted state health care expenditures
1986	The Washington Health Care Project Commission (Governor Gardner)	ESHB 2021, 1986 session	Address issue of the uninsured in Washington State, including (1) number and characteristics of the uninsured, (2) administrative structure of a plan to meet the needs of this population, and (3) the cost and financing of such a plan.
1987-88	Health Insurance Project (Governor Gardner)		Address Blue-Cross shortfall for covering state employee health benefits and the need for redesign of health benefits offered by the SEIB, including (1) options for restructuring the SEIB, (2) cost containment for the July 1, 1988 contract, (3) issues of data control, (4) options for short and long term alternatives, and (5) feasibility of self-funding.
1988-89	Washington Rural Health Care Commission (Governor Gardner)	SSB 6124, 1988 session	Develop recommendations on current rural health care issues, including (1) organization and administration of rural health care, (2) identification of basic health care services, and (3) financing of rural health care.
1989-90	Study of State Purchased Health Care (Governor Gardner)	SHB 2038, Health Care Reform Act of 1988	Conduct a study of all state-purchased health care and recommend strategies to make the State a more prudent purchaser of health care services.
1990-92	Washington Health Care Commission (Governor Gardner)	HCR 4443, 1990 session	Make recommendations for fundamental health system reform to achieve five goals: (1) control health system costs, (2) provide universal access to health services, (3) develop incentives for the use of appropriate and effective health services, (4) reform the health care liability system, and (5) improve state health care purchasing.
1993-95	Washington Health Services Commission (Governor Lowry)	SSB 5304, Washington Health Services Act of 1993	Develop rules to implement basic principles of health care reform including (1) universal access by 1999, (2) employer/individual mandates – ERISA waiver, (3) uniform set of health services including uniform benefits package and population-based public health services, (4) assistance for low-income persons through expansion of Basic Health and Medicaid, (5) reformed insuring entities (certified health plans) and health purchasing insurance cooperatives (HPIC's or Alliances), (6) capitated managed care, (7) maximum premium, and (8) state-wide health data system.

			Recommendations made in the following areas: (1) uniform benefits package and cost sharing, (2) community rating and maximum premium, (3) certified health plans, (4) transition approach, (5) quality assurance and improvement, (6) health services information system, (7) small business impacts, (8) long term care integration, (9) medical necessity, (10) public health improvement, (11) provider financial conflicts of interest, (12) Taft-Harley and public trusts integration, (12) major capital expenditures, (13) workers' compensation integration, and (14) medical savings accounts.
1995-97	Washington Health Care Policy Board (Governor Lowry)	ESHB 1046, 1995 session	General: Make recommendations on health care issues, review state agency rules for consistency with the goals of health reform, administer specific immunities from antitrust laws, and complete needed studies. Help achieve broad access to health coverage while controlling costs and maintaining or improving the overall quality of health services. Specific: By statute, the Board was to make periodic recommendations on at least the following; (1) scope, financing, and delivery of health care services, (2) long term care services, (3) use of health care savings accounts, (4) rural health care needs, (5) in-migration due to health reforms, (6) medical education, (7) community rating impacts, (8) quality improvement programs, (9) models for billing and claims processing forms, (10) guidelines to carriers for utilization management & review, provider selection & termination, and coordination of benefits & premiums, and (11) Medicare supplemental insurance. Board was also to review rules prepared by various agencies, make recommendations for managing services to children with special health care needs, and develop sample enrollee satisfaction surveys for use by health carriers. 1996 Report Included reports or recommendations on (1) comparative analysis of individual and group health insurance, (2) improving delivery of care to children with special health-care needs, (3) continuation of self-insurance for some public employee health benefits, (4) progress on developing a uniform program for assuring and improving health-care quality, (4) providing medical benefits for injured workers under an integrated system, (5) administering petitions by health organizations granted immunity from antitrust laws, (6) process for reviewing

			agencies' proposed regulations, (7) project to monitor and improve delivery of health care in select communities, (8) efforts to promote public dialogue and make health care information more available and relevant, and (9) emerging issues.
2001	Governor's Health Care Subcabinet (Governor Locke)	Executive Order	Develop and coordinate state health care policy and purchasing strategies. Provide a forum for exchanging information and coordinating statewide efforts to provide appropriate, available, cost effective, quality health care and public health care services to Washington citizens.

Note: This isn't an attempt to capture all the important activities during this time period (e.g., Public Health Improvement Plan) – just the more broad based commissions / committees focused on state-agency and statewide health care system changes.